Hospital Discharge Summary Report
Glossary
As of November 2006

Column Heading	Description
Discharges	The actual number of patients released from the hospital in a given category.
"PCT"	"Percent" – represents the calculated percentage of the preceding row and/or column.
Charges	Represents the accumulated dollar amount for services incurred during an episode of care*, but **does not** reflect actual costs of services; the amount billed to the patient or the specific amounts that hospitals received in payment.
Days	Represents the total number of days for each episode of care and is based upon the admission date.
"AVG LOS"	"Average Length of Stay" – represents the estimated time spent in the hospital for discharges in a specific category (row) and is calculated using the sum of the length of stay field for a specific category (row) **divided by** the number of discharges in that category (row).
"AVG Charge"	Represents the sum of charges for a specific category (row) **divided by** the total number of discharges in that category (row).
"AVG Age"	Represents the sum of ages in a specific grouping (row) **divided by** the total number of discharges in that category (row).

Row Heading	Description
Patient Age (Combined)	Represents age groupings in which record counts for both female and male patients are totaled. Patient age is calculated using the patient's date of birth upon admission.
Patient Age (Female)	Represents age groupings in which record counts for female patients are totaled. Patient age is calculated using the patient's date of birth upon admission.
Patient Age (Male)	Represents age groupings in which record counts for male patients are totaled. Patient age is calculated using the patient's date of birth upon admission.
Principal Diagnosis	Represents the diagnosis determined as the primary reason for a specific episode of care and/or admission. Subsections represent standard **International Classification of Diseases 9th Revision (ICD-9)** code ranges.
Diagnosis Code Count	Subsections represent each of the nine diagnostic code fields available in a single record. Actual counts are totaled for each field.
E-Code Count	"External Cause of Injury Code Count"–the total number of ICD-9 **external cause of injury codes** (E-Codes) reported in either of two E-Code fields ("E-Code 1" and "E-Code 2") in each record. The second E-Code (E-Code 2) corresponds to the "place of occurrence".
E-Code 1 Range (ALL)	"External Cause of Injury Code 1 (All Ranges)"-- Includes all external cause of injury code ranges from the ICD-9 standard list that are in the first E-Code field. **Includes** counts of those having no E-Code reported in the field.
E-Code 1 Range Excl Blank	"External Cause of Injury Code 1 Range Excluding Blanks"-- Includes all external cause of injury code ranges from the ICD-9 standard list that are in the first E-Code field ("E-Code 1"). The counts for records without E-codes are **excluded**.
Prin Proc ICD-9 (ALL)	"Principal Procedure **International Classification of Diseases 9th Revision** (All Ranges)" - Represents **ICD-9** procedure code ranges for primary procedures performed during an episode of care. **Includes** counts of records with no procedure codes reported in any of the six procedure code fields.
Prin Proc ICD9 Excl Blank	"Principal Procedure ICD-9 Ranges Excluding Blanks" -- Represents **ICD-9** procedure code ranges for primary procedures performed during an episode of care. **Excludes** counts of records with no principle procedure codes reported in any of the six procedure code fields.

Principal Procedure CPT-4	"Principal Procedure **Current Procedural Terminology, 4th Edition (CPT-4)**" - Represents procedure code ranges based on the CPT-4 numeric coding list. The CPT-4 coding system may be used as an alternate to the ICD-9 or HCPCS coding systems in ED records. (See HDD Data Specifications LINK)
Principal Procedure HCPC	"Principal Procedure **Healthcare Common Procedure Coding System" --** Represents procedure codes based on the HCPCS coding system (excluding Level I which are CPT-4 codes). The HCPCS coding system may be used as an alternate to the ICD-9 or CPT-4 coding systems in ED records.
Procedure Code Count	Subsections represent each of the six procedure code fields available in a single record. Actual counts are totaled for each field.
Patient Race	Codes represent color, ethnic affiliation or nationality of the person admitted. This field is not reported in ED records. (See Public Data Layout for specific codes and code definitions at http://www.azdhs.gov/plan/crr/ddr/rel/info.htm)
Patient Marital Status	Codes represent the (legal) conjugal status of the person admitted, in relation to the marriage laws or customs of the country. (See Public Data Layout for specific codes and code definitions at http://www.azdhs.gov/plan/crr/ddr/rel/info.htm)
Patient Sex	References the gender of the person admitted for care.
Discharge Status	References the disposition of the patient upon release from the healthcare facility following an episode of care. (See Public Data Layout for specific codes and code definitions at http://www.azdhs.gov/plan/crr/ddr/rel/info.htm)
Total Gross Charges	Refers to all charges incurred by the patient per episode of care.
Length of Stay	"LOS"-- refers to the duration of an episode of care in days, and represents the difference between the Discharge date and the Admission date where the Admission Date is **subtracted** from the Discharge date. If both dates are the same the LOS is 1 (e.g. newborns or emergency department records).
Charge Per Day	Subsections represent dollar amount ranges that correspond to charges incurred each day of an episode of care.
Payor Code	Represents the Primary Payor and/or expected source of payment for the majority of the charges associated with an episode of care. (See Public Data Layout for specific codes and code definitions at http://www.azdhs.gov/plan/crr/ddr/rel/info.htm)
Type of Admission	Represents a code that corresponds to the priority of admission. (See Public Data Layout for specific codes and code definitions at http://www.azdhs.gov/plan/crr/ddr/rel/info.htm)
Source of Admission	Represents a code that identifies the place and/or circumstance from which the admission originated. (See Public Data Layout for specific codes and code definitions at http://www.azdhs.gov/plan/crr/ddr/rel/info.htm)
Days to Procedure Count	The number of days from the date of admission, preceding the performance of the principal procedure.
Admit Day of the Week	References the seven days of the week patients were admitted to the hospital.
Attending Physician Board	Represents a numerical code that corresponds to a specific Arizona State Licensing board. (See Public Data Layout for specific codes and code definitions at http://www.azdhs.gov/plan/crr/ddr/rel/info.htm)
Operating Physician Board	Represents a numerical code that corresponds to a specific Arizona State Licensing board. (See Public Data Layout for specific codes and code definitions at http://www.azdhs.gov/plan/crr/ddr/rel/info.htm)
Record Type	References a numerical code that identifies a record as Inpatient, Emergency Department or other (see subsections).
Discharge Month and Year	The months of the calendar year during which a patient is released from a hospital. (Discharge counts in the first column correspond to the number of discharges per month.)

***NOTE: "Episode of Care" equates to one hospital discharge record and is used interchangeably with "hospital stay".**

Hospital Discharge Revenue Report
Glossary
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Revenue Code	Description
All Inclusive Rate (10X)	Flat fee charged either daily of for entire hospital stay for services rendered.
Room and Board–Private (11X)	Routine service charges for accommodations in a private room.
Room and Board–Two Bed (12X)	Routine service charges for accommodations in a semi-private room (2 beds).
Room and Board–3&4 Bed (13X)	Routine service charges for rooms containing three or four beds.
R & B–Private Deluxe (14X)	Deluxe accommodations substantially in excess of private room services.
Room and Board–Ward (15X)	Routine service charges for accommodations with five or more beds.
Room and Board - Other (16X)	Routine services charges for accommodations that cannot be included in the more specific codes. For example: Charges for a sterile room or other special accommodation.
Room and Board–Private (17X)	Accommodation charges for nursing care to newborns and premature infants in nurseries.
Room and Board–Private (18X)	Room and Board - Leave of Absence. Charges for holding a room while the patient is away temporarily.
Room and Board–Private (20X)	Routine service charges for patients who require care in an intensive care unit.
Room and Board–Private (21X)	Routine service charges for patients who require care in a coronary care unit.
Room and Board–Private (22X)	Charges for care during a hospital stay or on a daily basis for certain service not included elsewhere.
Room and Board–Private (23X)	Extraordinary charges for nursing services in addition to normal nursing charges.
R & B - All Incl Ancillary (24X)	Flat-rate charge that is applied for ancillary services only.
Pharmacy (25X)	Charges for medication distributed under the direction of a licensed pharmacist.
IV Therapy (26X)	Charges for administration of intravenous solutions by specially trained personnel.
Medical / Surgical Supplies (27X)	Charges for supply items required for routine care.
Oncology (28X)	Charges for treatment of tumors and related diseases.
DME, Other than Renal (29X)	Charges for medical equipment that can withstand repeated use. Excludes renal equipment (equipment related to care involving the kidneys).
Laboratory (30X)	Charges for diagnostic and routine clinical laboratory tests.
Laboratory Pathology (31X)	Charges for diagnostic and routine laboratory tests on tissues and cultures.
Radiology - Diagnostic (32X)	Charges of diagnostic radiology services including interpretation of results.
Radiology - Therapeutic (33X)	Charges for therapeutic radiology and chemotherapy to care and treat patients.
Nuclear Medicine (34X)	Charges for procedures and tests using radioactive materials as required for diagnosis and treatment of patients.

CT Scan (35X)	Charges for computed tomographic scans.
Operating Room (36X)	Charges for services of specifically trained nursing personnel during and immediately following surgery.
Anesthesia (37X)	Charges for anesthesia services.
Blood (38X)	Charges for blood or blood components.
Blood Storage / Processing (39X)	Charges for administration, processing and storage of blood or blood components.
Other Imaging (40X)	Charges for specialty imaging services for body structures (example: ultrasound or mammography).
Respiratory Services (41X)	Charges for respiratory services including oxygen and administration of some drugs.
Physical Therapy (42X)	Charges for therapeutic services for diagnosis or rehabilitation of patients with neuromuscular or orthopedic conditions.
Occupational Therapy (43X)	Charges for therapeutic interventions to improve, sustain, or restore a patient's level of function.
Speech Therapy (44X)	Charges for services related to impaired functional communication skills.
Emergency Room (45X)	Charges for emergency treatment.
Pulmonary Function (46X)	Charges for tests that evaluate a patient's ability to breathe.
Audiology (47X)	Charges for care related to hearing.
Cardiology (48X)	Charges for cardiac procedures.
Special Ambulatory Care (49X)	Charges for ambulatory surgery not covered by other categories.
Outpatient Services (50X)	Charges for services to an outpatient who is then admitted as an inpatient.
Clinic (51X)	Clinic visit charges for services to ambulatory patients.
Free Standing Clinic (52X)	Charges for an outpatient visit at a freestanding clinic.
Osteopathic Services (53X)	Charges for a structural evaluation by a doctor of osteopathy.
Ambulance (54X)	Charges for ambulance services necessary for transportation of the ill or injured to a medical facility.
Skilled Nursing (55X)	Charges for nursing services under the direct supervision of a home health licensed nurse.
Medical Social Svcs (56X)	Home health charges for services related to the patients social situation.
Home Health Aid (57X)	Home health charges for personal care of the patient.
Other Home Hlth Visits (58X)	Home health charges for visits other than for physical, occupational or speech therapy.
Home Hlth Units of Svc (59X)	Home health charges for other units of service not covered by other categories.
Oxygen (Home Health) (60X)	Home heath charges for oxygen and oxygen equipment and supplies excluding purchased equipment.
MRI (61X)	Charges for magnetic resonance imaging and magnetic resonance angiography.
Med/Surg (Ext of 27X) (62X)	Charges for medical/surgical supply items required for patient care.
Drugs Requiring Specific ID (63X)	Charges for medications that require additional service by a licensed pharmacist.
Home Therapy Services (64X)	Charges for home intravenous therapy.
Hospice Service (65X)	Charges for hospice care services for a terminally ill patient.

Respite Care (HHA Only) (66X)	Charges for non-hospice respite care.
Cast Room (70X)	Charges related to casts.
Recovery Room (71X)	Room charge for patient recovery after surgery
Labor / Delivery (72X)	Charges for labor and delivery room services by specifically trained nursing personnel.
EKG/ECG (73X)	Charges for operation of specialized equipment for diagnosis of heart ailments.
EEG (74X)	Charges for operation of specialized equipment for diagnosis of brain disorders.
GI Services (75X)	Charges for gastrointestinal procedures not performed in the operating room.
Treatment / Observation Room (76X)	Charges for use of a specialty room such as a treatment or observation room.
Preventive Care Services (77X)	Charges for preventive care services (example: vaccination).
Lithotripsy (79X)	Charges related to extra-corporal shock wave therapy (sound waves).
Inpatient Renal Dialysis (80X)	Charges for use of renal (kidney) dialysis equipment.
Organ Acquisition (81X)	Charges related to the acquisition and storage of body components used for transplantation.
Haematolysis O/P or Home (82X)	Charges for outpatient or home renal (kidney) dialysis.
Peritoneal Dialysis O/P or Home (83X)	Charges for outpatient or home peritoneal dialysis, a different form of renal (kidney) dialysis.
CAPD Outpatient or Home (84X)	Charges for continuous ambulatory peritoneal dialysis, another method of peritoneal dialysis.
CCPD Outpatient or Home (85X)	Charges for continuous cycling peritoneal dialysis, another method of peritoneal dialysis.
Miscellaneous Dialysis (88X)	Charges for dialysis services not identified elsewhere.
Psychiatric Treatment (90X)	Charges for individual mental health treatment and services
Psychiatric Services (91X)	Charges for mental health services not identified elsewhere.
Other Diagnostic Services (92X)	Charges for diagnostic services specific to common screenings for disease, illness or medical condition.
Other Therapeutic Services (94X)	Charges for other therapeutic services not otherwise identified.
Professional Fees (96X)	Charges for services from medical professionals that require separate codes.
Professional Fees (97X)	Charges for services from medical professionals that require separate codes.
Professional Fees (98X)	Charges for services not covered by other categories.
Patient Convenience (99X)	Charges for items generally considered strictly convenience items.
All Other	All other charges not covered by other categories.